MOTION FOR AWARD OF FEES AND DISBURSEMENTS
STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

18. REASON FOR MOTION: (CHECK ALL THAT APPLY)

- [ ] AWARD OF ATTORNEY'S FEES AND/OR DISBURSEMENTS (ATTACH ITEMIZED STATEMENT INDICATING DATES COVERED BY THIS MOTION)
- [ ] AWARD OF WITNESS FEES
- [ ] OTHER (EXPLAIN) _____

19. AMOUNTS REQUESTED:

ATTORNEY'S FEES: $ _____

DISBURSEMENTS: $ _____

WITNESS FEES: $ _____

OTHER: $ _____

TOTAL: $ _____

20. PAYMENT TO BE MADE TO:

_____
NAME

_____
STREET ADDRESS

_____
CITY, STATE, ZIP

CERTIFICATION AND SIGNATURE (Motion Must Be Signed)

21.

I,_____, hereby certify that I have caused a copy of this motion to be served upon counsel for the employer, (or, if there was no legal representation, directly upon the opposing party) _____
(Name)

at _____, on _____ by United States
(Address)   (Date)
mail, postage prepaid.

Signature _____   Date _____

ORDER

22.   THE EMPLOYER/INSURER IS ORDERED TO PAY THE PAYEE NAMED ABOVE THE SUM OF $_____
       AS FOLLOWS:

$ _____ FOR ATTORNEY'S FEES

$ _____ FOR DISBURSEMENTS

$ _____ FOR WITNESS FEES

$ _____ OTHER PAYMENTS

_____   _____
Hearing Officer   Date

WCB-25 (eff. 1/1/13)